Infirmary Admission Record

CCS CORRECT CARE SOLUTIONS

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

Admission to be completed by person receiving patient in infirmary

Date: _____ Time: _____

Admitting Diagnosis: _____

Vital Signs: Time: _____ Wt: _____ BP _____ Pulse _____ Resp _____ Temp _____

Known Allergies: ❑ None ❑ Yes, list and describe reaction:

Food: _____

Drug: _____

Emotional Status: ❑ Relaxed ❑ Cooperative ❑ Withdrawn ❑ Openly Anxious ❑ Uncooperative

Impairment:

Hearing: ❑ None Decreased: ❑ Rt ❑ Lt Deaf: ❑ Rt ❑ Lt Hearing Aid: ❑ Rt Lt

Vision: ❑ None ❑ Glasses ❑ Contacts ❑ Cataracts ❑ Artificial Eye ❑Glaucoma

Communication: ❑ Understands English ❑ Does not understand English

Drug or Alcohol Use: _____

Skin Assessment:

Presence of lesions: ❑ No ❑ Yes Describe: _____

Color: _____ Temperature: ❑ Warm ❑ Dry ❑ Cool ❑ Moist

Edema: ❑ No ❑ Yes Describe: _____

Fingernails: Color: _____ Capillary Refill: _____ Condition: _____

Toenails: Color: _____ Condition: _____

Physical Assessment:

Lung Sounds: _____

Pulses: _____ Heart Sounds: _____

Abdominal palpation: _____ Bowel Sounds: _____

Nutrition Assessment:

Last Intake: Food (Date/Time) _____ Fluid (Date/Time): _____

Recent weight changes (reason) _____ ❑ Increase ❑ Decrease

Difficulty swallowing: ❑ No ❑ Yes Describe: _____

Special Diet: ❑ No ❑ Yes Describe: _____

Feeding Tube: ❑ No ❑ Yes Type & feeding schedule: _____

Elimination Assessment:

Last Bowel Movement: _____ Constipation: ❑ No ❑ Yes Diarrhea:❑ No ❑ Yes

Urine: Frequency _____ Urgency:❑ No ❑ Yes Discharge: ❑ No ❑ Yes

Burning:❑No❑Yes

Potential for Injury:

Steady on Feet: ❑ Yes ❑ No Describe: _____

Aids to mobility: ❑ None ❑ Cane ❑ Crutches ❑ Walker ❑ Wheelchair ❑ Prosthesis

Recent Fall: ❑ No ❑ Yes Describe: _____

Signature: _____ Date: _____

D3001DP28837PNXN

Revised 07/08/2011

Infirmary Discharge Summary

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Admission Date:_____ Admitting DX:_____

Admitting Provider name:_____

Discharge Plan: (To be filled in at time of admission)

_____

_____

_____

Details of Infirmary Stay: (list treatments/Labs/diagnostics performed/Progress made)

_____

_____

_____

_____

_____

_____

_____

_____

_____

List meds ordered/given at discharge:

_____

Follow Up Care Needed:

_____

_____

Any Restrictions/Special needs:_____

- Education/instructions given to patient: Check Box after completion ☐

Nurse or provider Signature/Date of discharge:

_____

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Infirmary Progress Notes
FOR INFIRMARY USE ONLY

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Allergies _____

Date/Time	Comments:

revised 08.08.2011

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INFIRMARY Provider Orders

CCS CORRECT CARE SOLUTIONS

Patient Name	Patient Number	Booking Number	Date of Birth	Today's Date

Admitting Diagnosis: _____

Expected Length of stay (minimum is 24hrs): _____

Goals for Admission:

_____

Treatment Plan (What will be accomplished during this admission): _____

_____

Frequency of HCP visits (How often will a provider see patient): _____

_____

IV Therapy: Do you want an IV started: ☐ **YES or** ☐ **NO**

Solution to be administered: _____

Rate to be run: _____ **D/C Date:** _____

Other IV instructions: _____

Vital Signs and Nursing Visits: ☐ **Q Shift** ☐ **Daily** ☐ **Other:** _____

Intake and output: Do you want I&O ☐ **YES or** ☐ **NO**

Provider Signature/Date: _____

Nurse Noting Orders/Date: _____

Was this order received via telephone: ☐ YES or ☐ NO

revised 08/01/2010

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Medical Housing/Infirmary Care

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

Admission Patient Information

What you can expect in the Medical Housing/Infirmary Unit:

1. When there is a doctor or nurse practitioner in house, you will be seen. Typically, there is a provider in house Monday through Friday. No provider on Saturday and Sunday.
2. If your condition worsens, a nurse will assess you and notify a provider by phone.
3. Nurses will see you each shift and assess your condition and take your vital signs.
4. You must follow the DOC rules for the unit and they will be enforced – ask the Co for these rules.
5. Your condition will be monitored 24 hours a day - 7 days a week, by licensed medical staff which includes RN's, LPN's, and LNA's and a nurse practitioner or medical doctor Monday – Friday.
6. We have licensed Mental Health Providers 6 days a week in house as well as a psychiatric provider 2 times a week. If you would like to see a mental health professional please ask a nurse.
7. We have dental service 2 days a week and if you need to be seen by the dentist let the nurses know.
8. We also plan your discharge from the Infirmary from the start of your stay in the infirmary.

What we expect from you:

1. We will not tolerate threatening behavior, violent behavior or verbal abuse of any kind. If you participate in this type of behavior we will request DOC to move you to segregation and place a camera in your cell – by doing this, you could be putting yourself at risk.
2. We expect you to tell us honestly what your symptoms are – honest communication helps us help you.
3. You will keep your area clean.
4. That you shower daily, unless the provider has said not to.
5. We expect that you will eat and drink adequately.
6. You will follow your treatment plan.
7. If able to, you are required to:
    a. you will get up
    b. walk around
    c. sit up
    d. not lay in bed all day
8. Follow your discharge instructions.

Our goal is to take care of your medical and psychiatric needs so you can quickly return to your living unit. We want everyone to receive their care in a therapeutic environment.

Patient Signature/Date

revised 08/01/2010

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Provider Infirmary & Medical Housing Unit
Admission Orders

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Diagnosis/Chief Complaint:_____ Date:_____ Time:_____

Observation _____ Acute Care _____ Chronic Care _____ Hospice _____

GENERAL CARE:

Vital signs: TPR q _____BP q_____ Weight q_____ Neuro checks_____
Extremity checks_____ Other_____

Activity: Bed Rest_____ BRP_____ Chair_____ Ambulate PRN _____
Ambulate with assistance_____ Activity as Tolerated _____
Other activity restriction_____

Diet: NPO_____ Ice/Sips of Water_____ Clear Liq._____ Full Liq_____
Soft _____ Diet As Tolerated_____ General Diet_____
Other diet restriction _____

Nursing: O_2_____liters per minute by_____ Continuous_____ PRN____
IV (solution, rate, duration)_____
Intake and Output_____
Wound Care_____
Hot Pack/Ice Pack_____
Call Provider For: _____
_____

LAB/XRAY:

Chem. Profile _____ CBC _____ Urinalysis _____ INR _____ EKG _____
Other Labs: _____
Imaging Studies:_____
_____

Follow-up Appointment Orders:_____

Additional Orders:
_____
_____
_____
_____

Provider Signature: Date/Time _____

Nurse Signature: Date/Time _____

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Provider Infirmary & Medical Housing Unit
Admission Orders

CCS CORRECT CARE SOLUTIONS

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

MEDICATIONS:

True Medication Allergies: _____

_____

_____

Reported Medication Intolerances: _____

_____

Continue ALL current medications _____
Discontinue ALL current medications _____

New Medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Routine Medications:
Tylenol 325mg tabs ii PO qid prn ____
Ibuprofen 200mg qid prn _____
ASA 10gr PO qid prn _____
Antacid 30cc's or therapeutic equivalent q four hours PO prn _____
Milk of Magnesia 15-30 cc's PO bid prn _____

Provider Signature: Date/Time _____

Nurse Signature: Date/Time _____

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